CENTERSTOR	CMEDICARE & MEDIC	AID SERVICES	_			Oivi	IB 110: 0250-0521	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 00			COMPLETED	
		155208	B. WIN			06/23/2	2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ		
NAME OF F	PROVIDER OR SUPPLIER	t		l	LAGRANGE ROAD			
	ED NILIDOINIC CENIT	EB		1	/ER, IN47243			
HANOVE	R NURSING CENT			HANOV	/ER, IN4/243			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
F0000								
	This visit was fo	r Investigation of	F0	000	Submission of this plan of		1	
	Complaint IN00091793.				correction does not constitut	е		
	Complaint II too	0,11,00.			admission or agreement by	the		
	G 1 : (D)100	001702 G 1 4 4 4 1			provider of the truth of facts			
	1 *	091793 - Substantiated.			alleged or correction set fort	hon		
	No deficiencies i	related to the allegations			the statement of			
	are cited.				deficiencies. This plan of			
					correction is prepared and submitted because of			
	Unrelated deficie	encies cited			requirements under state an	d		
					federal law. Please accept the			
	C 1.4 I	22 122 2011			plan of correction as our cre			
	Survey dates: Ju	ne 22 and 23, 2011			allegation of compliance.			
	Facility number:	000115						
	Provider number	:: 155208						
	AIM number: 10	00291080						
		: D (1/ DN						
	Survey team: Je	nnie Barteit, KN						
	Census bed type:	:						
	SNF/NF: 63							
	Residential: 9							
	Total: 72							
	10111. 72							
	Census payor typ	pe:						
	Medicare: 4							
	Medicaid: 56							
	Other: 12							
	Total: 72							
	Cample: 11							
	Sample: 11							
	These deficienciencies	es reflect state findings						
	cited in accordar	nce with 410 IAC 16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TIZ811

Facility ID:

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155208		IDENTIFICATION NUMBER:	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/23/20	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HANOVE	ER NURSING CENT	ER			AGRANGE ROAD ER, IN47243		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0157 SS=D	Quality review 6/29 A facility must imm resident; consult w and if known, notif representative or a when there is an a	/11 by Suzanne Williams, RN nediately inform the vith the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the					
	potential for requir significant change mental, or psychological statuconditions or clinicalter treatment significant in exito adverse consecutive form of treatment form.	ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or is in either life threatening cal complications); a need to inficantly (i.e., a need to sting form of treatment due juences, or to commence a ment); or a decision to ge the resident from the					
	resident and, if known representative or in when there is a chassignment as spead change in reside State law or regular paragraph (b)(1) of the facility must resupdate the address resident's legal registantily member.	ecord and periodically s and phone number of the presentative or interested					
	facility failed to notified of a char for 1 of 4 residen	review and interview, the ensure the physician was nge in resident condition ats reviewed related to ation in a sample of 11.	F0:	157	The facility will ensure this requirement is met through the following corrective measures:1. Resident E is deceased.2. All residents hat the potential to be affected. Nurse's Notes reviewed for p 30 days to ensure physician	ıve	07/18/2011

l í					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155208	B. WIN	G		06/23/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	LAGRANGE ROAD	
HANOVE	ER NURSING CENT	ER		HANOV	/ER, IN47243	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG		DATE
TAG	Findings include The clinical recorreviewed on 6/22 record indicated included, but were pneumonia and construction. An Infection Corrindicated the resilucal hospital on prescription for a pneumonia. A physician's ordindicated a chest completed the for "wheeze and courindicated the resilucated the resilucation." The Care Plan W Respiratory Infectionicated, "Problem per respiratory by cough, [arrow [oxygen saturation]]	rd for Resident E was 2/11 at 8:25 a.m. The the resident's diagnoses re not limited to, thronic airway attrol Report, dated 4/8/11 dent returned from the that date with a an antibiotic for the derivative dentity was to be llowing morning due to gh." The order also dent was to start on the max for five days for		TAG	notification made when indicated.3. The Physician Notification with Acute Changin Condition policy and proces was reviewed and no change were indicated at this time (stattachment A). Licensed states were re-educated on this procedure. The DON or her designee will review Nurse's Notes and Respiratory There notes daily on scheduled wordays to ensure physicians ar notified timely with changes is condition (see attachment B) indefinitely.4. Findings of the audits will be reviewed during facility's quarterly Quality Assurance meetings and the of action adjusted according The above corrective measure will be completed on or before July 18, 2011.	ges edure es see in) ese g the s plan ly.5. res
		indicated, "Resolved."				
		•				
	A physician's ord	ler, dated 5/25/11				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 06/23/2	LETED	
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP COE LAGRANGE ROAD /ER, IN47243	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO!) CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated the res Prednisone (anti	ident was placed on -inflammatory) and tibiotic) for ten days due				
	but were not lim respiratory treati nebulizer twice of 2:00 p.m.; Duon daily at 6:00 a.m. 6:00 p.m., and 10 nebulizer every so oxygen at 2 liter	rs for June 2011 included, ited to, the following ments: Budesonide by daily at 6:00 a.m. and eb by nebulizer five times a., 10:00 a.m., 2:00 p.m., 0:00 p.m.; Duoneb by four hours as needed; s per minute (LPM), as oxygen saturation greater				
	6/17/11 indicated see re [about] pir footHas had oChest - some redema present lower extremitie chemistry] /BNF Elevate legs as to increasing Lasix status. Await lab prognosis is poodementia/advance pulmonary disease	eed chronic obstructive se"				
	Nurse's Notes in related to respira	dicated the following story assessment:				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP C LAGRANGE ROAD /ER, IN47243	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	6/17/11 at 10:45 [saturation] 96%	a.m., "O2 [oxygen] sat RA [room air]."				
	1	o.m., "Sa O2 [oxygen 6 L/S [lung sounds] dim				
	6/19/11 at 4:20 a CTA [clear to au	.m., "O2 sat 92% L/S scultation]"				
	6/19/11 at 11:00	a.m., "O2 sat 96% RA"				
	6/19/11 at 9:05 p - clear & dim"	o.m., "Sa O2 - 96% L/S				
	1	o.m., "Tol [tolerated] neb eatment] [symbol for no] mbol for with]				
	- exp. [expiratory lobe] - [symbol f	p.m., "Scattered crackles y] wheeze LLL [left lower for no] productive cough. up] SOA [shortness of al exertion"				
	for 6/22/11 for [a	o.m., "Placed on MD list arrow pointing down] O2 stion edema B [bilateral]				
		rapy Notes for 6/14 indicated Resident E's				

000115

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 06/23/2	LETED
	PROVIDER OR SUPPLIEF		410 W L	DDRESS, CITY, STATE, ZIP COI LAGRANGE ROAD (ER, IN47243	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	times daily on ear Documentation is oxygen saturation treatment was be Respiratory Then 1:54 p.m., indications sounding responsible through low 80's without didn't want to appropriate the same season of	dicated: o.m., "O2 sat 93%] O2 @ 2 LPM per N/C ed] [arrow pointing up], out] O2, O2 sat 80% nion list to see [name p.m., "Res awake ted resident O2 @ 86%				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO	00	li i	E SURVEY PLETED /2011		
	PROVIDER OR SUPPLIER		410 W	ADDRESS, CITY, STATE, ZIP CO LAGRANGE ROAD /ER, IN47243			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
TAG		sident's condition.	TAG	DEFICIENCY)		DATE	
		on 6/22/11 at 1:40 a.m. ident had expired.					
	the Director of N statement from R who she indicate medical director. dated 6/22/11 at the physician had review Resident "Her care had I with her POA [powith nursingT followed care disconcur with nurs with change in C factors. Indeed, reminded the nur prognosis/import comfortable. No been given unles evidence of being additional medic. During interview LPN #24 indicate for Resident E diccomfort measure.	scussed with POA. I ing decision not to call 22 sat due to above I would have politely see of the diagnosis/poor tance of keeping patient onew orders would have s patient showed g uncomfortable/needing ation for comfort needs." To on 6/23/11 at 4:15 p.m., sed the physician's orders ad not include an order for s only.					
		10 p.m., the Director of d the facility's policy					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155208	B. WING		06/23/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	S.		LAGRANGE ROAD	
HANOVE	R NURSING CENT	ER		/ER, IN47243	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	entitled, "Physici	ian and Family			
	Notification Proc	cedure." Procedure #2,			
	which was under	lined, indicated, "Notify			
	the physician of any change in condition				
		not warrant a change in			
	the treatment pla	•			
	the treatment pla	11.			
	2.1.5(.)(2)				
	3.1-5(a)(2)				
	3.1-5(a)(3)				
F0164		he right to personal privacy			
SS=E and confidentiality of his or her personal and clinical records.					
	Cillical records.				
	Personal privacy in	ncludes accommodations,			
		, written and telephone			
		personal care, visits, and			
		and resident groups, but			
	-	ire the facility to provide a			
	private room for ea	ach resident.			
	Except as provide	d in paragraph (e)(3) of this			
		ent may approve or refuse			
		sonal and clinical records to			
	any individual outs	side the facility.			
	_	nt to refuse release of			
		cal records does not apply			
		is transferred to another tion; or record release is			
	required by law.	uon, on record release is			
	. oquilou by law.				
	The facility must k	eep confidential all			
	information contain	ned in the resident's			
		s of the form or storage			
methods, except when release is required by					
		r healthcare institution; law;			
		nt contract; or the resident.	E0164	The facility will ensure this	07/12/2011
	based on observa	ation, interview, and	F0164	requirement is met through	07/13/2011
				1 requirement is met timough	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155208	A. BUII B. WIN			06/23/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
LIANOVE		TED		1	LAGRANGE ROAD		
HANOVE	ER NURSING CENT	IER		HANOV	'ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	record review, th	ne facility failed to ensure			the following corrective		
	the resident's pri	vacy was maintained			measures:1. Residents B, C		
	during care for 6 of 6 residents reviewed				I, K, J and L were not harme		
	1				All residents have the potent	iai to	
	for privacy during care in a sample of 11 residents. (Residents B, C, H, I, K, and J)				be affected. See below for corrective measures.3. The		
	1	-			Pre/Post Basic Nursing Skills	3	
	The deficient practice also affected 1 of				Policy and Procedure was	-	
	11 sampled residents (Resident L) when				reviewed and no changes we	ere	
	her roommate's privacy was not				indicated at this time (see		
	maintained.				attachment C). Nursing staff	f	
					were re-educated on this		
	Findings include	··			procedure. The concern was		
	I mamga marata	•			discussed with the physician involved as well. The DON or		
	1 On 6/22/11 or	t 5.15 a m CNA #11 was			designee will randomly obse		
		t 5:15 a.m., CNA #11 was			staff prviding personal care t		
	1 ^	ing personal care for			(3) times daily, on scheduled		
		e curtain between bed and			working days, for two (2) wee		
	door into the hal	lway/common area of the			then three observations per		
	nursing unit was	not pulled closed. CNA			for four (4) weeks, then three	9	
	#11 provided inc	continent care and assisted			observations per month for to		
	1	artially don her pants.			months, then quarterly there		
	_	v at this time, CNA #11			to ensure privacy is maintain		
	_				Further, she will observe one physician interaction with a	;	
		ould get the nurse to help			resident per week for four we	eks	
	_	lent's pants up and assist			then one per month for two	JCRO,	
		the wheel chair. Without			months, then one per quarte	r to	
	pulling the curta	in, and leaving the room			ensure privacy is maintained		
	door open, CNA	#11 exited the room.			attachments D and E).4. The	`	
		nained lying uncovered in			findings of these audits will b		
		nts down to the thighs,			reviewed during the facility's		
		x #11 and the nurse to			quarterly Quality Assurance		
	_	THIT and the nuise to			meetings and the plan of act		
	return.				adjusted accordingly.5. The above corrective measures v		
					completed on or byefore July		
		t 5:30 a.m., CNA #17 and			13, 2011.	'	
	RN #8 were obs	erved providing			 		
	incontinent care	for Resident C. Resident					
		esident L. was seated in					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		ľ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/23/2	ETED	
		100200	B. WIN			00/23/2	UII
NAME OF I	PROVIDER OR SUPPLIEF	8		1	DDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD		
HANOVE	ER NURSING CENT	ΓER		1	ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		between the two beds in					
		urtain between the beds					
	-	and the curtain between					
		loor was not pulled. The					
		vers were removed, and					
	-	cluded cleansing of the					
	urine and stool from the resident's						
	perineal area, application of a barrier						
	cream, and repositioning of the resident.						
	The resident's lower body was uncovered						
	as RN #8 opened the door and left the						
	room to obtain needed supplies.						
	#7 were observed for Resident I. The bed and door to be pulled. CNAs #3 incontinent care brief. Before the applied, a knock. The resident was curtain between remained open.	the curtain between the the hallway was not 3 and #7 provided and applied the resident's e resident's pants were was heard at the door. Is lying in bed, and the the bed and door CNA #5 opened the ad into the room, and said, port now?"					
	was observed at within the dining secured unit. Re tables in the dining serving lunch tra	the nurse's station located gactivity room on the esidents were seated at ng room, and staff were session where Resident H					

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 06/23/2	ETED
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER		410 W	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD VER, IN47243	•	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PERCEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E .	(X5) COMPLETION DATE
was seated. MD #21 "Mr. [name], you're g right in your food." asked staff, "Is this ty Resident H] - is this h The doctor put her sta resident's chest and sta Resident H], I'm goin heart." MD #21 aske	stated to Resident H, going to fall asleep The doctor then spical for [name of show he usually is?" ethoscope to the tated, "Mr. [Name of the stated, "Mr. [Name of the stated, "Do we to bed when he's like 5 p.m., LPN #12 was lood pressure cuff that arm of Resident K. ted in the soft the secured unit. In the room, and the or the unit was sectivities. After the resident's eff ear. 10 p.m., CNAs #15 deproviding toileting that J. The resident the room in her wheel commode was placed wheel chair. The door and the wheel ode was not pulled.				DATE

	OF CORRECTION	IDENTIFICATION NUMBER: 155208	A. BUII		00	COMPL 06/23/2	ETED
		155206	B. WIN			06/23/2	011
	PROVIDER OR SUPPLIEF			410 W L	ddress, city, state, zip code AGRANGE ROAD ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	pulled down. At in the commode, as she was assist take steps to her was in bed, her princontinence car the care, a knock. The curtain between the curtain between the care, a knock of the curtain between the	mode, as her pants were fter the resident urinated her pants were pulled up ded to stand and pivot and bed. After the resident beants were removed, and de was provided. During to was heard at the door. The door opened, and de #18 looked directly into Nursing provided facility and a copy of "Your Rights me Resident" on 6/23/11 wiew of the document to have the right four room and during treatment, and personal					
F0282 SS=D	facility must be pr in accordance wit plan of care. Based on record	ided or arranged by the ovided by qualified persons heach resident's written	F0	282	The facility will ensure this requirement is met through the	he	07/18/2011
		ensure respiratory e administered as ordered			following corrective measure Resident E is deceased.2. A	s:1.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) I			3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		155208	B. WIN			06/23/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				LAGRANGE ROAD			
HANOVE	ER NURSING CENT	ER			/ER, IN47243			
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES		ID	,	(X5)		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
		· · · · · · · · · · · · · · · · · · ·			residents receiving respirato			
for 1 of 2 residents reviewed related to respiratory medications in a sample of 11.					therapy have the potential to	· .		
	1 ^ -	cations in a sample of 11.		atory				
	(Resident E)				therapy MAR's were audited	to		
					ensure treatments are being			
	Findings include	:			administered as ordered.3.			
					Licensed nursing staff were re-educated on the Physician	2'0		
	The clinical reco	rd for Resident E was			Orders and Medication	13		
	reviewed on 6/22	2/11 at 8:25 a.m. The			Administration policies (see			
	record indicated	the resident's diagnoses			attachments F and G).			
	included, but we	C			Additionally, all were inservio	ced		
	pneumonia and c	•			and the need to review the	iew the		
	obstruction.	in one an way			respiratory MAR's when a			
	obstruction.				respiratory therapist is not present in the facility, as nurs	ning		
	D1	C I 2011: 1 1 1			is then responsible to admini			
	l -	s for June 2011 included,			those treatments as ordered	•		
	but were not limi	ited to, the following		l l				
	respiratory treatn	nents: Duoneb by			The DON or her designee wi monitor the respiratory MAR			
	nebulizer five tin	nes daily at 6:00 a.m.,			ensure treatments are			
	10:00 a.m., 2:00	p.m., 6:00 p.m., and			administered as ordered dail	·		
	10:00 p.m				scheduled working days for t			
	1				weeks, then twice weekly for weeks, then weekly for two	two		
	The Medication	Administration Record			months, then monthly therea	fter		
		2011 indicated the			(see attachment H).4. The			
	following related				findings of these audits will b	e		
	ı				reviewed during the facility's			
	1 ^ -	nents for June 1 through			quarterly Quality Assurance	:		
	21, 2011:				meetings and the plan of act adjusted accordingly.5. The			
		1.0			above corrective measures v	l l		
		ninistered five times			completed on or before July			
	1	on 6/1, 6/9, 6/11, 6/12,			18,2011.			
	6/15, and 6/20/11	1. The 10:00 p.m. dose						
	of Duoneb was n	ot administered on any of						
	the other 15 date	s. The 6:00 p.m. dose						
	also was not adm	ninistered on 6/8/11.						
	During interview	completed on 6/22/11 at						
		1				!		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION 00	(X3) DATE S COMPL	
		155208	A. BUII B. WIN			06/23/2	011
	PROVIDER OR SUPPLIER ER NURSING CENT		<u></u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE _AGRANGE ROAD /ER, IN47243		
(X4) ID PREFIX TAG	(EACH DEFICIEN) REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0309 SS=D	indicated the resprovide all respir 5:00 a.m. and 5:3 week. She indicates respiratory treatment the 10:00 p.m. do dates indicated. 3.1-35(g)(2) Each resident must must provide the notattain or maintain physical, mental, a in accordance with assessment and passed on observatinterview, the fact was planned and pain for 1 of 1 reto pain in a samp (Resident C) Findings include: On 6/22/11 at 5:3 RN #8 were observed in the resident was lyin mattress with the The resident was	ation, record review, and cility failed to ensure care implemented to manage sident reviewed related le of 11 residents.	F0	309	The facility will ensure this requirement is met through the following corrective measures: 1. A plan of care related to pain for resident C implemented. 2. All residents have the potential to be affect All plans of care were review ensure plans of care for pain were present if indicated. 3. policies and procedures for C Plan Development and Pain Management were reviewed no changes were indicated a time (see attachments I and Licensed nursing staff were re-educated on those policies certified nursing staff were al re-educated on Pain Management. The DON or hold designee will randomly obserstaff providing personal care	was steed. The Care and this J).	07/18/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	155208		LDING	00	06/23/2		
		100200	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2		
NAME OF I	PROVIDER OR SUPPLIEF	R			LAGRANGE ROAD			
HANOVE	ER NURSING CENT	TER .		1	/ER, IN47243			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	· ·				CROSS-REFERENCED TO THE APPROPRIAT	ΓE		
(X4) ID PREFIX TAG	back. The resid pillow. CNA #1 elevated to help resident's perinea grimaced. CNA resident they wo too much - I kno indicated, "It hur the resident was moaned, and RN you're in pain. I that." When the completed, RN # C, "You don't loo good. You want resident nodded, indicated she was medication and when the complete control of the clinical recording to the clinical recording to the clinicated on 5/2/11 with donot limited to, "pspecified/other control of the clinical recording to the clinicated on 5/2/11 with donot limited to, "pspecified/other control of the clinical recording to the clinicated on 5/2/11 with donot limited to, "pspecified/other control of the clinical recording the clinicated on 5/2/11 with donot limited to, "pspecified/other control of the clinical recording the clinicated on 5/2/11 with donot limited to, "pspecified/other control of the clinical recording the clinic	ent's right arm was on a rindicated the arm was with pain. As the al area was cleansed, she #17 indicated to the uld "try not to move you with thurts." RN #8 ets when she moves." As repositioned, she I #8 indicated, "I know feel bad. I hate to do repositioning was #8 indicated to Resident ok like you're feeling too pain medicine?" The "Yes," and the nurse is going to get the pain would return. For d for Resident C was 2/11 at 8:45 a.m. The the resident was admitted itagnoses including, but pain, not otherwise thronic pain."		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	two ur (4) ons en e pain eview ekly if n 5 en K and udits plan y.5. res	(X5) COMPLETION DATE	
		nent - Cognitively						
		ed pain by grimacing,						
	•							
	tearing, moaning, crying, whimpering, rubbing body parts, and irritability.							
		c) Minimum Data Set ent, dated 5/14/11,						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP CO LAGRANGE ROAD (ER, IN47243	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated the res pain or possible	ident had indicators of pain daily.				
	the Director of N MDS is now cor assessment for p	on 6/22/11 at 9:20 a.m., Jursing indicated the sidered the facility's ain, and that the resident's to pain should be in her				
	Physician's orders for June 2011 included, but were not limited to, Duragesic (pain medication) patch, 50 mcg, change every three days; Lortab 10/500, take 1 every four hours as needed for pain; morphine sulfate (Roxanol), 100 mg/5 ml, take 0.5 ml every two hours as needed for moderate pain; and Roxanol, 1 ml, every two hours as needed for severe pain. The PRN (as needed) Medication Flow Sheet for June 1 through 22, 2011, indicated the resident had received pain medication 26 times. Each time pain medication was administered, the pain was rated at "5 worst pain possible" except 6/13/11 at 4:00 p.m. when the pain rating was "4 very severe pain." Attempted interventions prior to the pain medication administration was "Position change" on each entry. Medications administered included Roxanol, 1 ml and 0.5 ml and Lortab 10/500. The medication was indicated as "Effective"					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		ISTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155208	A. BUIL			06/23/2		
			B. WINC	_	DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				AGRANGE ROAD			
HANOVE	R NURSING CENT	ER			ER, IN47243			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
	for each administ	tration.						
	During interview completed on 6/22/11 at 3:15 p.m., the Director of Nursing indicated Resident C's MDS should have triggered for a care plan related to her pain.							
	During interview on 6/23/22 at 2:10 p.m., the Director of Nursing provided copy of an inservice presentation she indicated would be provided to nurses. The inservice indicated, "Please ensure that prior to any potentially pain causing experience (i.e. dressing change, T&R [turn and reposition], etc.) that a resident is premedicated [symbol for with] pain meds [medications] if requested, or if known to have increased pain during such procedures."							
F0328 SS=D	proper treatment a special services: Injections; Parenteral and ent Colostomy, uretero Tracheostomy care; Tracheal suctioning Respiratory care; Foot care; and Prostheses. Based on intervie	ostomy, or ileostomy care; e;	F0.	328	The facility will ensure this requirement is met through the following corrective measure		07/18/2011	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	 TIZ811	Facility ID	-		ge 17 of 25	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155208 06/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 W LAGRANGE ROAD HANOVER NURSING CENTER HANOVER, IN47243 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE assessed and care was planned and Resident E is deceased. There was a care plan present for her implemented for a resident with signs and chronic respiratory disease, which symptoms of respiratory illness for 1 of 2 addressed assessment for signs residents reviewed related to respiratory and symptoms to monitor for which included increased edema, care in a sample of 11. (Resident E) adventitious breath sounds and productive cough.2. All residents Findings include: have the potential to be affected. See below for corrective During interview on 6/22/11 at 4:55 a.m., measures.3. The policies on Nursing Charting and Care Plan CNA #11 indicated Resident E expired Development and Review were earlier during the night due to pneumonia. reviewed and no changes were CNA #11 indicated the resident had been indicated at this time (see coughing, and her oxygen saturation attachments L and I). Licensed staff were re-educated on these levels were low, and she passed away. policies. The DON or her CNA #11 indicated the resident's passing designee will review Nurse's was a shock. Notes daily, on scheduled work days, to determine if changes in condition have occurred, been During interview on 6/22/11 at 5:05 a.m., assessed appropriately, timely LPN #2 indicated Resident E had CHF physician notification is made and (congestive heart failure), had been on an the condition is care planned (see antibiotic for pneumonia and had a low attachment B) indefinitely.4. The findings of these audits will be grade temperature. LPN #2 indicated the reviewed during the facility's resident was [age] years old, and the quarterly Quality Assurance "body wears out." meetings and the plan of action adjusted accordingly.5. The above corrective measures will be The clinical record for Resident E was completed on or before July reviewed on 6/22/11 at 8:25 a.m. The 18, 2011. record indicated the resident's diagnoses included, but were not limited to, pneumonia and chronic airway obstruction. A note written in bold handwriting in the front of the record indicated, "Do not send

STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED	
		155208	B. WIN			06/23/20	11	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			1	LAGRANGE ROAD			
HANOVE	ER NURSING CENT	ER		1	/ER, IN47243			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Res [resident] to	hospital under any						
	circumstances per [name] res guardian." The note was dated 9/12/10, and also indicated, "P.S. Keep comfortable here!"							
	The Care Plan W	orksheet for						
	"Pneumonia," dated 4/8/11, indicated the							
	· ·	esident has pneumonia						
		decreased oxygen						
		undated, handwritten note						
	on the Care Plan	indicated, "Resolved."						
	An Infection Cor	ntrol Report, dated 4/8/11						
	indicated the resi	dent returned from the						
	local hospital on	that date with a						
	prescription for a	in antibiotic for						
	pneumonia.							
	During interview	on 6/23/11 at 4:25 p.m.,						
	~	fursing indicated the						
		ll the family of Resident						
	· -	her to the hospital, and						
	·	decide if the resident						
	should go to the							
	should go to tile	nospitai oi not.						
	1 * *	ler, dated 5/19/11,						
	indicated a chest	-						
	completed the fo	llowing morning due to						
	"wheeze and cou	gh." The order also						
	indicated the resi	dent was to start on the						
	antibiotic Zithror	max for five days for						
	upper respiratory	_						
	The Care Plan W	orksheet for "Upper						

000115

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL 06/23/2	ETED	
		130206	B. WIN			00/23/2	011
NAME OF I	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
HANOVE	ER NURSING CENT	rer			LAGRANGE ROAD ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 1	ction," dated 5/19/11,					
	indicated, "Problem: The resident has an						
	1	infection as evidenced					
	1 2 2 2	pointing down] sats					
	1	on], abnormal lung					
		dated, handwritten note					
	on the Care Plan	indicated, "Resolved."					
	A physician's ord	der, dated 5/25/11					
	1	ident was placed on					
		-inflammatory) and					
	Doxycycline (antibiotic) for ten days due to upper respiratory infection.						
	le apper respirat						
	Physician's order	rs for June 2011 included,					
	I -	ited to, the following					
		nents: Budesonide by					
		daily at 6:00 a.m. and					
		eb by nebulizer five times					
	_	i., 10:00 a.m., 2:00 p.m.,					
	1 -	0:00 p.m.; Duoneb by					
		four hours as needed;					
	I -	s per minute (LPM), as					
	1	oxygen saturation greater					
	than 90%.	onygen saturation greater					
	During interview	y on 6/22/11 at 10:30					
	a.m., the Directo	or of Nursing indicated					
		ot have a current care					
	plan related to he	er respiratory condition,					
	_	t currently on an					
		Director of Nursing					
		plan is developed when					
		ntrol Practitioner is					

AND PLAN OF CORRECTION DENTIFICATION NUMBER: 155208 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Informed a resident has an infection. O0 COMPLETED 06/23/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE ROAD HANOVER, IN47243 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	ON
informed a resident has an infection.	
A Physician's Progress Note, dated 6/17/11 indicated, "Subjective: Asked to see re [about] pitting edema right footHas had ongoing cough. Objective:Chest - some rhonchiExt [extremity] - edema presentPlan: venous doppler lower extremities. Check Chem 7 [blood chemistry] /BNP [B-natriuretic PEP]. Elevate legs as tolerated. Consider increasing Lasix based on labs/clinical status. Await lab results. Overall prognosis is poor due to dementia/advanced chronic obstructive pulmonary disease" Nurse's Notes indicated the following related to respiratory assessment: 6/17/11 at 10:45 a.m., "O2 [oxygen] sat [saturation] 96% RA [room air]." 6/18/11 at 9:15 p.m., "Sa O2 [oxygen saturation] - 94% L/S [lung sounds] dim [diminished]" 6/19/11 at 4:20 a.m., "O2 sat 92% L/S CTA [clear to auscultation]" 6/19/11 at 11:00 a.m., "O2 sat 96% RA" 6/19/11 at 9:05 p.m., "Sa O2 - 96% L/S	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/23/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	ER NURSING CENT			1	_AGRANGE ROAD 'ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	LIX, IIV47243		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
	6/20/11 at 8:00 p [nebulizer] tx [tr distressLS [syr crackles" 6/20/11 at 10:30 - exp. [expirator] lobe] - [symbol p [arrow pointing air] upon minima 6/21/11 at 1:00 p for 6/22/11 for [a sats chest congest feet" Respiratory The through 6/21/11 Duoneb treatment times daily on ear Documentation is oxygen saturation treatment was been as the state of the s	p.m., "Tol [tolerated] neb reatment] [symbol for no] mbol for with] p.m., "Scattered crackles y] wheeze LLL [left lower for no] productive cough. up] SOA [shortness of					
	1 3270 311 141. 02						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	NSTRUCTION		(X3) DATE COMPI	
AND PLAN	OF CORRECTION	155208		A. BUILD	ING	00		06/23/2	
		100200		B. WING				00/23/2	O 1 1
NAME OF P	ROVIDER OR SUPPLIER					DDRESS, CITY, STA			
H∆N∩\/F	R NURSING CENT	FR				.AGRANGE RO ER, IN47243	JAD .		
				ot		LIX, IINT/240			- axe
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULI		DI DI	ID REFIX		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT TCIENCY)	E	DATE
	92% on 2 LPM a								
	7270 OH 2 EH W u	ind ditter neo.							
	6/21/11 at 9:15 n	m "O2 sat 93%							
	6/21/11 at 9:15 p.m., "O2 sat 93% [symbol for with] O2 @ 2 LPM per N/C								
		ed] [arrow pointing up],							
	_	out] O2, O2 sat 80%							
		nion list to see [name							
	of doctor]."	iioii iist to see [iiaiile							
	or doctorj.								
	6/21/11 at 11·15	p.m., "Res awake							
		ted resident O2 @ 86%							
	temp [temperatur	_							
		rn [as needed] Tylenol							
		policy and procedure]."							
	per order & p/p [poncy and procedure.							
	Documentation i	n the Nurse's Notes failed	1						
		sident's physician was	•						
		sident's condition as							
		se's and Respiratory							
	Therapist's Notes								
	Therapists i votes	.							
	A Nurse's Note o	on 6/22/11 at 1:40 a.m.							
		ident had expired.							
	The Medication	Administration Record							
		2011 indicated the							
	following related								
	respiratory treatn								
	Budesonide was	administered two times							
		ugh June 21, 2011.							
	. ,	<i>5</i> , –							
	Duoneb was adm	ninistered five times							
		on 6/1, 6/9, 6/11, 6/12,							
FORM CMS-2	567(02-99) Previous Version)· TI7	 Z811	Facility I	D: 000115	If continuation sl	neet Do	ge 23 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155208	B. WIN			06/23/2	011
		l	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	_AGRANGE ROAD		
HANOVE	ER NURSING CENT	ΓER		1	'ER, IN47243		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		1. The 10:00 p.m. dose					
	of Duoneb was not administered on any of						
	the other dates.						
	Duoneb was adn						
	(prn) basis on 6/2	21/11 at 11:50 [a.m. or					
	p.m. not specifie	ed]. No other prn					
	administrations of	of Duoneb were indicated.					
	Oxvgen saturation	ons were not indicated as					
	1 20	time on the MAR in June					
	2011.						
	2011.						
	Ovygen at 2 I PM	M was indicated as used					
	1	with a specific time not					
	1 '	with a specific time not					
	indicated.						
	D =:== :== :=						
	_	v completed on 6/22/11 at					
	_	irector of Nursing					
		spiratory therapists					
	1 ^	ratory treatments between					
		30 p.m. seven days a					
	week. She indic	ated nurses provide the					
	respiratory treatr	ments at other times.					
	During interview	v on 6/23/11 at 2:10 p.m.,					
	the Director of N	Jursing provided a					
	statement from F	Resident E's physician,					
	who she indicate	ed was the facility's					
		. The statement was					
		5:11 p.m., and indicated					
		d been requested to					
		d and indicated, "Her					
		scussed by myself with					
	Care mad Deem di	scussed by myself with					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155208		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SU COMPLE 06/23/20	TED	
	PROVIDER OR SUPPLIER		410 W I	ADDRESS, CITY, STATE, ZIP CODE LAGRANGE ROAD 'ER, IN47243	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	nursingThe cadiscussed with P nursing decision O2 sat due to abowould have polit the diagnosis/poof keeping patien orders would have patient showed e uncomfortable/n medication for contraction for contr	omfort needs." on 6/23/11 at 4:15 p.m., ed the physician's orders d not include an order for				